Health Information Technology Policy Committee
Final
Summary of the July 10, 2012, Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 38th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC website. She conducted roll call, and then turned the meeting over to HITPC Vice Chair Paul Tang.

2. Review of the Agenda

Tang explained that this meeting would feature an update from the Centers for Medicare and Medicaid Services (CMS) related to attestation, barriers, and Regional Extension Centers (RECs). The meeting also included briefings on some long-term and post-acute care initiatives, information from hearings on patient-generated data and clinical quality, and an update from ONC.

> **Action Item #1:** Minutes from the June 6, 2012, HITPC meeting were approved by consensus.

Before moving forward with the agenda, Tang invited Deven McGraw to provide the group with information related to a hearing sponsored jointly by the HITPC Privacy and Security Tiger Team and the HIT Standards Committee's (HITSC) Privacy and Security Workgroup. McGraw explained that the hearing, to be held the day after this HITPC meeting, would focus on the issue of trusted identity of providers in cyberspace. Committee members were invited to attend, and reports from the hearing will be presented at future HITPC and HITSC meetings.

3. Remarks from the National Coordinator

National Coordinator for Health Information Technology Farzad Mostashari reported that the ONC received a total of 140 submitted comments in response to the Request for Information (RFI) on the governance rule. ONC staff members are analyzing the comments and will report back to the Committee. Mostashari acknowledged and thanked Josh Seidman, who will be leaving ONC, for his efforts related to improving health and health care for the patient and his work with the Meaningful Use Workgroup and other ONC activities.

4. Data on Stage 1 Meaningful Use Attestation and Barriers

Robert Anthony of CMS reported that the CMS had roughly 10,000 registrants in the month of May, bringing the total to almost 250,000 registrants for the program to date. This increase is consistent with previous months.

In May, there was almost $168 million in Medicare meaningful use payments, bringing the total to more than $2.8 billion Medicare incentive payments. As has been the case, family practice and internal medicine are the groups receiving most of the payments, but there is a wide range of specialties represented in meaningful use and in fact, 57% of eligible professionals (EPs) receiving incentive payments through Medicare are non-primary care specialists. Anthony noted that there has been a slight dropoff in EP payments in May, but an increase is expected by the end of the year (which would be consistent with last year's pattern). Anthony noted that nine Medicare Advantage Organizations have been paid, including more than 11,000 EPs for a total of almost $190 million.

Anthony commented that Medicaid is also on track. There were 4,160 EPs paid in May; the bulk of those were for adopt, implement, upgrade (AIU), but there were 182 for meaningful use in May as well. A total of 101 hospitals have been added for AIU and 12 hospitals on the Medicaid side for meaningful use. The total for Medicaid was just over $200 million, bringing payments close to $2.7 billion total. The official total for the program through the end of May is $5.7 billion and more than 113,000 providers paid so far through the program.

Anthony also explained that approximately 73% of hospitals have registered to participate in the program (a total of 3,662 hospitals), and 2,438 unique hospitals (about 48% of the total of all eligible hospitals) have been paid under the program. Of the total 521,600 EPs who can participate in the program, about 31% (roughly 163,000) are registered for Medicare and about 15% (or approximately 81,000) are registered for Medicaid—overall close to 50% of EPs are currently registered in the program. With regards to the Medicare side, almost 20% of all EPs have received a payment, meaning that 1 out of every 5 are either meaningful users or have made financial commitments to an electronic health record (EHR). More than half of the EPs receiving incentives are specialists.

For June, it looks like close to 9,000 EPs have been paid, bringing the total to about 122,000 providers being paid. Through the end of June, close to $6 billion in incentive payments have been disbursed through the program.

With regard to attestation, Anthony explained that 74,000 EPs have attested with close to 1,400 hospitals represented. Not much is known about the barriers to attestation—very few have been unsuccessful. No hospital has attested unsuccessfully, and only 274 out of 74,000 EPs have attested unsuccessfully. CMS is not seeing a significant change in the most popular menu objectives or the least popular menu objectives. EPs and hospital scoring are relatively the same and specialists are scoring the same high marks as primary care providers, although there is obviously a difference in the menu items that they choose and the objectives that they exclude. Anthony reviewed the most and least popular menu objectives.

CMS has been examining the difference between the nearly 50% of providers who have registered for the program and the 20% who have actually been paid through program to identify barriers to receiving payment. Barriers have fallen into six general categories: (1) knowledge gaps, (2) technical support, (3) vendor support, (4) information that was particular about specialties, (5) return on investment and productivity concerns, and (6) state on-boarding. Anthony noted that at the time much of this information was collected, there were fewer states that were on-boarded, representing a much larger barrier for AIU payments. There are now 45 states on board and CMS expects the rest to be on board by the end of 2012; this is now less of a concern as a barrier. Knowledge gaps appear to represent the most significant barrier. Some individuals indicated that they were not aware of the next steps after registering for the program. Others indicated that they were unaware of existing resources, lacked basic knowledge about eligibility criteria, or did not know about the actual requirements for meaningful use. Other knowledge gaps identified include not understanding whether there is a benchmark to hit for clinical quality measure reporting and not understanding payment adjustments/penalties. As a result of these findings, CMS is making great efforts to improve basic-level education resources, including a basic introduction for both Medicare and Medicaid on the CMS website. Some of the education resources are geared toward office and practice managers, others toward small practices. The CMS is continuing to work towards developing materials specific to each audience. CMS is also working on partner association and organization outreach.

In terms of technical support, CMS found a knowledge gap about certified products, about what constitutes a certified EHR, and how the certification process works. CMS is working with ONC to develop materials to educate about certified EHRs. There was also an indication that there is a lack of information specifically in relation to the program about what people should look for in an EHR. CMS and ONC have developed a series of national provider calls and are expanding the certification section of the CMS website (with links to the ONC website). The CMS is developing a basic certification guide in concert with ONC and is trying to emphasize that the RECs are in place to provide this type of support.

With regard to vendor support, some providers indicated that they are having issues with vendors that are not familiar with meaningful use issues or are not providing enough information on meaningful use issues. There was also an indication that there may be a lack of support for basic technical issues such as customizing or adapting an EHR to a particular workflow. One significant complaint related to the on-boarding delay for software implementation.

In the specialty-specific information category, there was a perceived gap about how meaningful use works with particular specialties (e.g., how particular objectives would be adapted to particular specialty workflows). The CMS has discussed with ONC about creating some REC education materials to address this issue and there are some existing REC education materials in this regard. CMS is also working with partner associations on a number of webinars with customized information. CMS is increasingly working towards breaking down more of its materials by particular specialty.

Particularly among physicians, one of the most significant barriers relates to return on investment and productivity issues—the identification of a lack of financial resources to implement this, a concern about the loss of revenue that would occur during implementation, how long that implementation period would be, the loss of staff time to that implementation or to the use of EHRs in general, and a general theme of the perception of burden of health care reform in general. The CMS intends to work closely with partner associations on these issues to develop outreach targeted to particular physician workflows and specialties. CMS is working with organizations such as Medscape to advance the return on investment discussion. Anthony presented testimonials from physicians discussing the return on investment and productivity issues; these testimonials are available online.

Dawn Heisey-Grove of ONC then discussed REC-reported practice-level challenges to achieving meaningful use. In November 2011, RECs were asked to enter site-level challenges that they have observed. Challenges were grouped into the following categories: (1) practice issues, (2) vendor issues, (3) attestation process issues, (4) meaningful use measures, and (5) an "on track" category. ONC has developed secondary and tertiary groups within these categories, with the goal of presenting solutions in a concise way on the Web portal that RECs use to find tools and solutions. Ultimately, the best solutions will be included on healthit.gov.

Heisey-Grove explained that roughly 15,000 REC-reported issues have been identified, and ONC is working to address those challenges that are still problematic while identifying those that have been resolved. She further explained that issues can be resolved at the site or provider levels. At the site level, an issue would be resolved if the REC indicates that the issue is "completed," a new issue is created to indicate that the site is now on track, and an "on-track" issue is resolved if a new issue is created. At the provider level, all challenges are resolved if the provider receives a meaningful use payment from CMS. There are other ways a provider may have a challenge resolved (e.g., attestation process issues are resolved when a payment is received from CMS).

Heisey-Grove presented the top 10 overall challenge categories by number of providers impacted, explaining that meaningful use measures has ranked first overall, but provider engagement has been the top issue for the month of May. The other eight challenge categories, in order from #3 - #10, are vendor selection, administrative practice issues, vendor delays in implementation/installation, workflow adoption, Medicaid program not up yet, vendor upgrades, vendor HER reports slow/not available, and practice financial issues. Heisey-Grove also presented the top 10 new and top 10 resolved issues for the month of May, followed by data on the top 10 meaningful use measure-specific issues and top 10 categories for providers trying to reach meaningful use.

By looking at monthly trends, ONC has been able to identify the up-and-coming issues as well as those issues that have been resolved. Overall, the largest increase has been in vendor-related technical issues, but many of these are being resolved or have been resolved since the data were collected.

Heisey-Grove explained that the ONC is working with a group of EHR vendors to review these challenges and develop solutions for practices facing these challenges. Identified solutions will be fed from the vendors back to the RECs so that they can provide this information in their work with providers. As appropriate, there are plans to also funnel these vendor-provided solutions onto the healthit.gov page.

Overall almost 50% of the issues that have been reported by RECs are practice-level issues (i.e., problems with staffing, administrative issues, provider engagement, etc.). Vendor issues represent about 29% of the problems, followed by the attestation process (12%) and specific problems associated with the meaningful use measures (11%). In terms of resolving these issues, 24% of the attestation process challenges have been resolved, 10% of the meaningful use measures challenges have been resolved, and 13% of both vendor issues and practice-level challenges have been resolved.

Although these data have not been broken down by provider specialty, Heisey-Grove noted that the top 5 challenges vary by practice type, pointing to the need for specialists to have specific tools that address their specific problems. Each group is facing different sets of problems—the RECs are focusing on targeting specific groups and using these data to prioritize their efforts in helping physicians.

Discussion

Marc Overhage asked about overall success with meaningful use and whether the AIU numbers could be pulled out of the data presented by Anthony. Overhage also noted that in one of the testimonials Anthony presented, a physician indicated that they were getting roughly a $63,000 benefit. He asked if this was typical and about how these aggregate over time. He also asked about the lingering, longer term costs over time. Anthony noted that CMS can pull the data out to separate meaningful use from AIU in an effort to help ONC and the Committee as Stages 2 and 3 approach.

Gayle Harrell thanked Anthony and Heisey-Grove for their presentations and expressed concern that many RECs are not helping to address situations for specialists. She commended ONC and CMS for the tools and other progress made to date in helping specialists, and noted that more work in this area is needed. Harrell asked about inconsistencies across RECs and why some appear to be more successful than others. Heisey-Grove explained that REC representatives hold regional meetings to highlight success stories, identify challenges, and provide information on lessons learned. Seidman added that some RECs started off more equipped to manage their tasks than others, and that the RECs have developed communities of practice in various areas (e.g., meaningful use, vendor selection, etc.) to build communities around best practices. He explained that there is very little up-front funding for RECs and that most of the money they receive is based on meeting certain milestones (e.g., milestone 1 is for getting providers signed up, milestone 2 is for getting them live on an EHR, etc.). RECs have a strong incentive for supporting all of their providers in reaching meaningful use.

Charles Kennedy asked about the linkages between the meaningful use program and the ACO Federal program and whether there is any insight into how physicians are able to use the meaningful use process to become ACO enabled. Anthony commented that the CMS is looking into this issue. Seidman commented that there are also efforts underway to examine the impact on patient-centered medical homes.

5. Updates on Long-Term and Post-Acute Care (LTPAC) Initiatives

Larry Wolf opened this presentation by commenting on the shift from focusing on the EPs and eligible hospitals and the need to get them their incentive payments to looking more broadly at the health care system in this country and identifying how to ensure that the technology in place meets the needs of the whole population. Wolf explained that post-acute care refers to individuals coming out of an acute care hospital where they have had some major event and need time to heal, recuperate, and rehabilitate. Long-term care involves those who have some level of disability or some level of chronic needs. The providers for these two groups often interweave the kinds of services they offer. At times, it can be difficult to determine what is going on because the two populations have been blended in much of the reporting and regulations.

Wolf explained that regardless of the specific care setting, there is a significant emphasis on interdisciplinary teams and much of the care is delivered by other clinical staff and not physicians. In terms of chronic needs, much of the care is done by the individuals themselves and their support networks, which have any number of non-professionals involved. Among the providers of these populations, there is a sense of being aligned with national priorities for quality health care.

The Long-Term Post-Acute Care Health IT Collaborative has been key in terms of pulling together the various players in this area, holding annual summits, involving participation from federal agencies, and developing a series of roadmaps. The most recent roadmap seems to align very well with many of the issues facing the HITPC. For example, there is a large emphasis on care coordination, quality and process improvement, business imperative, consumer and care giver activation and engagement, and workforce acceleration.

Wolf noted that there has been an increasing emphasis on the importance of the care summary CCD. What is also needed, however, is the development of a broad care plan that recognizes the complexity of the patient's condition and the fact that there are multiple agents supporting that plan and that it is being carried out longitudinally over time.

Approximately one-third of Medicare hospital discharges receive some amount of care after that hospitalization. Roughly 61% of Medicare hospital discharges will eventually get some kind of home health care. The biggest initial destination is skilled nursing facilities typically as a short stay. Then, many of those patients go on to get home health, may go on to get outpatient rehabilitation, and/or long-term acute hospitals and in-patient rehabilitation. Almost two years ago, the American Hospital Association (AHA) released a report illustrating that for the long-term acute-care hospitals (LTACs), the mix of patients that goes to these settings is different and wide ranging.

Wolf pointed out that there are shifts in terminology from setting to setting, and the focus on the kind of care that is being provided may lead to additional questions. Several of these settings have required assessments that need to be carried out and submitted electronically. Historically these assessments have been different, have collected different information, and have reported the information differently. The Continuity Assessment Record and Evaluation (CARE) prototype system is intended to be a multi-setting assessment tool that could be used in all of these settings, including acute care settings. CMS is currently evaluating CARE. Wolf also acknowledged the work being carried out by the National Quality Forum (NQF) in its Measure Applications Partnership (MAP) project that is looking across all the care settings to develop a consistent set of measures.

Wolf presented some of the requirements stated by ONC in the proposed rule for Stage 2 that identify a base EHR and what its capacity should be. It is important to identify the minimum necessary for all settings to: (1) provide a base for process and quality improvement, (2) ensure a legal medical record, (3) improve care coordination/standards and interoperability, (4) measure and report quality, and (5) enable a learning health care system. Modular certification has been used by some of the vendors in this space to indicate that their product can meet the specified criteria. In addition, the Certification Commission for Health Information Technology (CCHIT) has created a comprehensive certification program for long-term and post-acute care with specific focus on nursing facilities and home health agencies.

Wolf noted that as indicated by a 2009 AHA survey, acute care hospitals have higher health information technology adoption than long-term acute care hospitals, rehab hospitals and psychiatric hospitals.

Wolf explained that care coordination is multistep. Because LTPAC settings tend to be lower tech, there is a significant amount of ongoing coordination during the admission. Some of the interdisciplinary team is on site, but typically there are no labs onsite. Often there is an off-site pharmacy. Rehabilitation services may be provided by another organization. In short, there are many players involved that need to coordinate what they are doing.

Almost 2 years ago, ONC awarded additional funds to health information exchange (HIE) activities in Colorado, Massachusetts, Maryland, and Oklahoma to specifically address how to improve coordination of care. Slightly different approaches are being taken in each state. The National Governor's Association has also done some work in this space.

Discussion

Joshua Sharfstein asked about the relationship between Medicaid and long-term care facilities and how this fits in. Wolf commented that there is a significant concern in this area that payments are below need, particularly with regard to Medicaid payments. Higher payments for Medicare are in a way helping the facilities stay afloat so they can provide services to the Medicaid patients. On the other hand, Medicaid is, in a way, paying the "room and board rate" and keeping these facilities open. Sharfstein added that one of the factors that has taken away the incentive for more efficiency and modernization is the fact that there are conflicting incentives in place. As those get resolved, an expectation from the largest payers is emerging that there be efficient care across the inpatient and long-term care facilities.

Harrell noted that Medicaid is funded 50% by the states, which can lead to significant challenges in states such as Florida, where 65% of people in nursing homes are paid for through Medicaid. States should have increased involvement in these issues.

Mostashari asked about the types of data elements that might be important for the LTPAC transition that may not have already been represented in the transition of care data elements in meaningful use and certification. Wolf explained that structurally, the CCD does a very good job of capturing history. However, his sense is that most of the receiving systems are not able to do anything with the granular data. Rather, they are looking to be able to receive it as a document and have a human being read it. Although not ideal, this is a step in the right direction. Along those lines, physicians often are allowed weeks to generate a discharge summary, but more and more, discharge summaries are arriving with the patient.

Judy Faulkner noted that one of the significant issues is terminology and asked about the difference between the terms "short-term acute care hospital" and "acute care hospital." Wolf explained that short-term acute care is what is traditionally called "acute care" or "general hospital," and added that long-term acute care hospitals are licensed as acute-care hospitals. Typically, the phrase "long-term care" means nursing center, and a patient could be in a nursing center for a long time because of a general decline in his or her ability to take care of themselves at home or in some other non-institutional setting. The notion of skilled nursing comes into play in the rehabilitation side of nursing (i.e., the short stay). Faulkner noted that there appear to be two different ways that long-term post-acute care groups could use software—one is that a health care organization itself who works closely with those long-term post-acute cares wants the same system in all, and the other is that the long-term acute care vendor wants to have consistency across all the places that they take care of.

Christine Bechtel asked if there was anything that could be done relative to meaningful use to accelerate the uptake of the Direct protocols to do secure e-mails and other activities in LTPAC facilities. Wolf noted that access to Direct is still mostly in a pilot-type environment, but there is an initiative in Massachusetts that is looking to create community-wide information exchange as an option by the end of this year. However, there is a lot of collective learning still happening on how to make Direct work. Bechtel suggested that ONC and CMS could explore ways to advance Direct more aggressively in the long-term care community.

Neil Calman asked about the overlap in the vendor community between the acute care hospital and long-term care. Are different vendors supporting these organizations? Wolf explained that historically, it has been a very separate process. However, there has been a move toward traditional mainstream hospital-based vendors to integrate with both hospital and ambulatory sides and create a common technology base. Calman also asked about transferring functional status information. Wolf explained that functional status and the care plan are hot topics in this area and are being worked on by the Longitudinal Care Coordination Group at the Standards and Interoperability (S&I) Framework. There is not a good structured standard at present. Care plans can be written completely from a clinician's perspective, but what becomes of greater value is a care plan that incorporates the patient's goals and priorities, and the interventions are a means to reach these.

Mostashari pointed out that there has been a concern that meaningful use and the certification of EHRs may have stifled innovation in the health care IT marketplace, that the attention that has gone into meeting the requirements may have hindered progress in the more platform-based application approaches, and that if the outcomes and the payments are set accordingly then perhaps that innovation could be unleashed without specifying the actions and the structures of care. The LTPAC community provides an opportunity to look at that hypothesis—is there in fact some innovation that isn't being seen perhaps as much of in the areas where there are eligible providers in hospitals in the LTPAC side? Wolf agreed that it is interesting to thing about opportunities for innovation in these areas. He anticipates seeing exchange drivers happening not at the level of sort of a CCD, but as components such as progress notes and other snippets of information (e.g., labs, etc.).

Madhulika Agarwal pointed out that at the Veterans Administration, there is a pilot project underway whereby caregivers of those who have had serious injuries are using iPads and have the information that is needed at the point of care. The program has just been launched and information will be forthcoming. McGraw asked about getting critical information to caregivers, which is an important component of ensuring care continuity, good transitions and good care for the patient, particularly in the home health care setting (but not exclusive to that). Are there any issues from a policy or technology standpoint to ensure that caregivers are in the information loop in the way that providers are? Wolf commented that many of the incentives are based on market forces. Consumers asking for more information will drive providers and subsequently their vendors to be able to deliver that information. Pressure is increasing on all providers to make good connections to the individual and their care team so that there are good handoffs and re-hospitalizations and other health care issues due to a lack of communication are avoided.

Harrell asked about trends in innovation and the approaches taken by vendors to integrate records. Wolf commented that there is a great deal of technology being addressed to people managing their health and providing support at home long term (e.g., heart rate monitors that tie into mobile devices). People are beginning to use this technology as consumers, in a way putting technology out there that is not necessarily medical grade. The providers are reluctant to get involved, but it is clearly changing the landscape.

Connie White Delaney commented that the discharge planning work, particularly with functional health status, is a strong contribution of nursing as well as related health care providers and the more that this contribution can be enabled, the more this key need can be addressed. She added that it generally includes the patient's family perspective as well.

6. Report from Hearings on Clinical Quality and Patient-Generated Data

Clinical Quality Hearing

David Lansky noted that a clinical quality hearing was held on June 7, on whether the HITECH meaningful use Program is moving the field into greater capabilities to improve quality of care. The hearing encompassed not only the quality measures activities, but also some of the meaningful use functionality and especially clinical decision support.

The hearing, sponsored jointly by the HITPC and HITSC, featured four panels: (1) high-performing health care improvement organizations and analytics systems to support them; (2) clinical decision support, the "improvement" arm of quality improvement; (3) e-measures; and (4) EHR vendor perspectives of necessary components of quality improvement. Lansky noted that four major themes emerged during the hearing:

- Meaningful use has unleashed tremendous energy across providers and vendors.
- There are significant learnings, even from the first months of meaningful use stage 1.
- The opportunity to leverage the "common substrate" to support quality improvement across EHR implementations.
- The emergence of a growing set of tools to populate and manipulate the "common substrate."

Lansky explained that a number of challenges facing providers and vendors were discussed during the hearing. There are inadequate standards, especially value sets. There is no clear link between requirements for decision support and quality measures, and insufficient payment incentives to drive deep adoption. Even the most advanced sites have substantial unstructured data, and difficulty identifying the "source of truth." There is concern about new fields and requirements—users want to better leverage the data that has already been captured. The most effective quality improvement occurs across "communities" and through mutual education, but systems are siloed.

With regard to quality measures, Lansky explained that some view them as defining targets for improvement activity, and so should be at the process level. Others prefer few measures linked to major care processes (6-7 metrics per process), with drill-down done locally; perhaps a federal identification of the "top 10 conditions." Standard, downloadable e-measure specifications are needed. Also needed is the same data model for quality measures as for drill-down that supports quality improvement. Lansky added that attribution to provider level remains a constant challenge, and that quality measure development should include collaboration with the CDS community.

In terms of quality improvement, testimony from the hearing suggests that local institutions are now building their own tools for drill-down analysis. Data integration to support analysis remains difficult (such as from claims or remote sites). Current eCQMs do not leverage new data elements in EHRs effectively, and there is a need to migrate to an "app-like" architecture to allow specialized vendors to solve some problems, rather than having EHR vendor "do it all."

Another major topic discussed during the hearing was clinical decision support. Lansky explained that facilities are building their own CDS alerts based on guidelines, but is this realistic (or efficient) for all meaningful use sites? A plug-and-play mechanism is needed to bring national "knowledge assets" into the EHR decision support functions (some experimental models now exist), and standard, downloadable CDS specifications are needed as well. Organizations want real-time visibility into care goals that are measured—this is a key strategy for improvement and likely CDS intervention.

Key policy questions for the HITPC that surfaced during the hearing include:

1. What is the HITECH role in quality measurement and clinical decision support? and
2. Should CDS and quality measures linked, or are they intentionally different (i.e., CDS represents prescriptive process guidance; quality measures measure whether outcomes are improved)?

Other issues include the fact that vendors need value sets and need to know what is coming over time. Work is needed to identify how best to include the patient as an actor in the design process.

Discussion

Bechtel asked about the technology implications of needing the same data model for quality measurement as for drill-down that supports quality improvement. She asked whether that puts the field in the position of being able to support only the process measures at the expense of or limiting the focus on the bigger picture outcomes measures. Lansky commented that the HITSC may be the group to consider the data model implications, and that conversation has not yet occurred. Bechtel suggested reframing the question to ask how best to support the purpose of quality improvement, which does require more of a focus on individual processes, while at the same time enabling a more robust kind of quality measurement that is more outcome based and patient centered. A data model that limits either should be avoided; both are needed.

Bechtel also asked about the HITECH role in quality measurement and decision support, and about increased innovation in the development and use of more robust quality measures. Lansky indicated that with regard to innovation, there was not much discussion at the hearing. A few individuals pointed to the value in having more national clarity on a shorter set of measures that are of high relevance to the providers in each condition or each specialty. The broad concept of using meaningful use as a test bed was not specifically addressed. Bechtel suggested that the workgroup could think about meaningful use as more of an innovative testing ground in an effort to reduce the angst that providers, purchasers, and consumers feel around the issue of having a better set of measures.

Tang noted that during the hearing, it was suggested that a waiver could be used to support new measures.

David Bates suggested that clinical decision support and quality measures should be related, because the decision support has the condition based on the quality measure. The measures tend to change over time, however, so they should not be "hard wired." He indicated that what may be most important is to begin building some of the value sets so that definitions can be identified without having to do significant work related to repurposing them. Charles Kennedy agreed and emphasized the importance of an infrastructure to support clinical decision support and quality measures.

Harrell noted that it is important to consider the "plug and play" aspect to make sure that there is a mechanism in place for some sort of certification or approval so that there is the ability to change over time as guidelines change and the decision support that is appropriate for those guidelines is in place.

Patient-Generated Data Hearing

Eva Powell explained that this hearing began with the presentation of a White Paper commissioned by ONC to RTI that provided background information, including a broad definition of patient-generated data and made some important distinctions between data capture, data transfer, and data review. The paper listed some barriers, including processing power, the fact that not all patient-generated data is of equal value, and that it varies by situation and health literacy.

Powell discussed the following themes that emerged during the hearing:

- Patient-generated health data is cross-cutting and has applications in each meaningful use policy priority.
- Specifying a plan for collection and use of patient-generated health data, along with clear objectives and goals is a key component of successful efforts.
- Information must be meaningful and useful for both patients and providers.
- Modularity and mobility are critical.
- Attribution of source is critical, but this is true for all information as we move toward integrating data from multiple data sources.
- Standards are important, but sharing of information is paramount.
- Much patient-generated health information is accommodated by current standards.
- Patient-generated health data should follow the same standards as all other information.

In terms of quality, safety, efficiency, and disparities, testimony and feedback at the hearing indicated that patient-generated health data can be a triggering function for clinical decision support; this is critical for patient-reported outcome measures. Patient-generated health data can be pivotal in addressing disparities, and the Patient-Reported Outcomes Measurement System (PROMIS) work should be leveraged (e.g., map proprietary tools to PROMIS, which is non-proprietary).

With regard to patient engagement, patient-generated health data is critical for shared decision-making, on both individual and population levels. Powell explained that the use of assessment scales was mentioned as being useful for individualized care and for resource allocation.

Powell then discussed topics from the hearing related to care coordination. At the hearing, it was suggested that the patient be thought of as an HIE of one. Creating a supportive environment between encounters requires an ongoing, two-way communication loop in which both patient and provider are acting on information they get in between encounters. The collection of caregiver status is important, as is the use and availability of community resources.

In terms of public health, there are implications with regard to adverse events and safety. Other considerations include post-marketing surveillance and the use of information for setting expectations and decision-making. Powell also noted that in terms of privacy and security, requirements are needed for data integrity, sourcing, metadata, etc. Patient authentication is essential for trust, and a mobile platform needs to be accommodated.

Powell then listed some potential next steps for the HITPC, such as designing criteria to require the collection and use of patient-generated health data while leaving room for individual variation. There are logical and achievable starting places, such as pre-visit communications and questionnaires/responses.

Discussion

McGraw explained that during the hearing, it was suggested that there be space in the clinical record to document when a physician receives patient-generated health data that is relied on to make a judgment, whether through a direct incorporation of patient data or just a physician's account of an encounter with a patient. Tang noted that ONC is conducting a legal review of how space can be created and used to accommodate patient-generated data into the legal medical record. Powell noted that at the hearing, it was also mentioned that using EHRs and HIT in general is stretching the purpose of the medical record—this is a bigger issue that may need to be revisited.

Harrell asked about liability issues and about ONC's definition of the medical record. Tang explained that ONC is examining the legal implications of what constitutes the legal medical record, and the staging where data flows to the provider and there is an "acceptance" or "acknowledge" that then incorporates data into the medical record, and whether there are timeliness expectations surrounding this. McGraw suggested that AHIMA and HIMSS be asked for input on this issue.

Calman reminded the group that everything that is entered into the medical record under the "history" section is patient generated. He added that secure messaging runs into some of the same issues as patient-generated data. Does the message itself and its answer get incorporated into the record?

7. ONC Update

Jodi Daniel, ONC, highlighted the fact that a goal had been set for 100,000 healthcare providers to become meaningful users by the end of 2012. That goal was achieved by June and represents about 20% of all the EPs in the United States. Additionally, the RECs are working to get health care providers to become meaningful users and are currently working with 133,000 primary care providers, 10,000 specialists, and over 70% of small practice providers in rural areas.

Daniel discussed meeting with HIT vanguards that occurred in June with the goal of discussing work in achieving meaningful use of EHRs. Present at the meeting were diverse stakeholders from 34 states, and participants were invited based on input from ONC grantees. Discussions included best practices to achieve meaningful use as well as HIT adoption in medically underserved communities.

Daniel provided an update on the certified HIT products list, reporting that there are now up to 1,477 unique certified EHR products. The programs in place have helped promote competition in the EHR market and have succeeded in making many products available for providers to choose from.

Enhancements have been made to the CHPL website including hybrid certification, a way of trying to help those who are practicing in both ambulatory and inpatient settings to use a combination of EHR technology to attest to meaningful use and receive incentive payment. There are important improvements in navigation and search functionality to help people understand which products are certified and to support that activity.

At this point, regulations and meaningful use rules are in process and continue to be worked on. Daniel emphasized the group is in the process of reviewing comments on the governance RFI. A total of 140 comments from a diverse set of stakeholders were received and can be viewed on regulations.gov.

A contractor sponsored a roundtable for ONC that brought together a diverse set of stakeholders in the LTPAC space and facilitated a lot of the activity that is now being discussed in the Meaningful Use Workgroup through the Care Coordination Subgroup. A White Paper is being developed and will be made public.

Regarding behavioral health, Daniel reported that a roundtable is scheduled for later in July. The focus is providers that are not eligible for meaningful use, but that are critical to the provision and coordination of care. She noted that it would be helpful to have a FACA member participate and asked committee members to contact her if any are interested in participating. The goal is to focus on the integration of behavioral health in primary care and understanding the data needs of providers, of the systems, policies, practices in order to ensure that the behavioral health providers have what is needed and to ensure a good exchange of information between behavioral health and primary care.

Daniel noted that a project on prescription drug monitoring programs is in the works with a focus on trying to get information from prescription drug monitoring programs into the hands of prescribers and dispensers in real time. Two pilots are underway in Indiana and Ohio, with the hope of additional pilots in the future. An S&I initiative has just kicked off called Health eDecisions. The goal is to take clinical practice guidelines and put them in common format so it can be shared and consumed by EHRs.

Lygeia Ricciardi, Office of Consumer eHealth, stressed the need to engage patients in their care if health care and health is to be more successful. Ricciardi emphasized the impact of patient engagement and provided an example of patients over 50 who have at least one chronic condition—those who are more rather than less engaged in their health are much less likely to be readmitted to the hospital within 30 days, less likely to experience a medical error, and less likely to suffer a health consequence from poor communication among providers.

Ricciardi discussed the “three As” for consumer engagement: access, action, and attitude. Access is about giving consumers secure, timely electronic access to their health information. Action is about supporting the development of tools, devices, and services that make that information useful so people can pick it up and do things with it. Attitude is about supporting people's evolution and their thinking about consumer’s roles, provider roles, and getting the word out about HIT. Ricciardi described a few initiatives at the Office of Consumer eHealth that cross all three “A’s.” The Office’s Pledge Program launched last September with about 30 organizations and involves different pledges for data holder organizations that may or may not be eligible for meaningful use. The requirement is that they make information easily, electronically available to patients. The program now includes about 100 data holder organizations. The program also includes a pledge for non-data holder organizations that can develop a tool, a technology, or a platform that supports the use of this data. The Office supports these organizations by providing tools, information, and opportunities for networking.

Last month, as part of the Office's Health Data Initiative, a consumer track was held that highlighted a lot of the successes of pledging organizations who had done noteworthy things in living up to their pledges. There will be an anniversary event September to build on that and to highlight the great successes to the press. There will be working sessions in which some of these organizations can work more closely with one another, form partnerships and push forward progress in all three areas. In addition, other Pledge Program initiatives include roundtables on social media and the underserved and papers on Mitigating Unintended Consequences of Consumer Engagement and Personalized Media are under development.

Ricciardi introduced a cancer initiative, still in the early phases, that is much more focused. Cancer was chosen as it tends to be more prevalent and patients and families tend to be engaged. A roundtable was held last month in partnership with NCI and eHealth on planning a long-term research agenda in consumer engagement in cancer care. The next steps are a pilot involving patient access to "liberated" data to plug into a platform to launch in the fall. Collaboration has been with several health care provider organizations in Texas, as well as a major platform provider and some cancer organizations and consumer organizations. There will be a research component as well as an "apps developer" challenge.

Ricciardi discussed the Patient Access Summit, held on June 4th in partnership with the VA and the White House about patient access to data with the goal of "turbo-charging" patient access to data. Identified areas for technical work include auto blue button, patient ID and authentication, and standardizing content especially for claims data.

Regarding recent action progress, together with the partnership of Veterans Affairs, the Office issued a $75,000 challenge for developers, which builds on the current Blue Button feature that allows patients to download their health information and share it with health care providers, caregivers and others that they trust. The challenge requires the development of a tool that will help individuals to use their health information, combined with other types of information. The goal is to better help the patient understand their own health status and make more informed decisions regarding their health care. Winners will be announced September 2012.

On July 23rd, a recently developed HIT animation will be released to the general public. Building on that, the Office has been encouraging people to tell their own stories about HIT specifically through some crowd-sourced video challenges. Also coming in the near future is the upgrading of healthit.gov which has a section for patients and families that gives them basic information about HIT and its benefits.

Tang asked when the paper on unintended consequences is due to be released. Ricciardi noted the paper is due out in September. McGraw expressed concern regarding the concept of an auto download and the aspect of users having to set up an account to access data. Ricciardi stated that the hope is that the blue button will have several available options for a user to select from.

Calman noted that the "Unintended Consequences" paper is a bad name for the paper. Ricciardi responded that "Unintended Consequences" will not be the official name of the report. Jodi Daniel went on to say the concern is valid and to the extent that something is released on this, measures will be taken to ensure the way it is framed is done well and that in terms of approaches to mitigate any potential risks, there will be some strong input and messaging on what are things that can be done or that we will be doing to mitigate risk. Calman suggested combining the paper with a document that outlines the benefits of HIT.

8. Public Comments

Chantal Worzala, AHA, commented on Anthony's presentation and noted that there are more than 1,000 hospitals (about 20% of all hospitals) that have met meaningful use. However, there has not been even progress among different groups of hospitals. There are 1,300 critical access hospitals that provide care in remote and rural areas, and only 9% of the critical access hospitals have met meaningful use. To fully benefit from the Medicare incentive program, critical access hospitals have to meet meaningful use by September 30 of this year. Worzala explained that across the Medicare Program, a hospital submits more than 90 quality measures to CMS. Across all payers, many hospitals are generating hundreds of quality measures. She emphasized the need to accelerate the pace and leverage the efficiency of automated reporting to get a small set of valid, reliable, and feasible quality measures that can be built upon.

Shelly Spiro, Pharmacy e-Health Information Technology Collaborative, noted that her group represents more than 250,000 individuals as members of the National Pharmacy Association and key pharmacy organizations involved in HIT. She noted that the Collaborative participated in the prescription drug monitoring program workgroup activities mentioned earlier by Daniel. In addition, Collaborative members participate in the long-term, post-acute care and behavioral health initiative, providing medication-related expertise for these practice settings. Pharmacists play an integral role in the interprofessional health care team in providing medication related patient care services outside and in conjunction with prescription dispensing functions.

Spiro explained that the pharmacy industry has a roadmap and would be glad to provide that to the members of the HITPC. The roadmap outlines the goals, objectives, and strategies for pharmacists to adopt and implement meaningful use of the EHR. Late last year, the U.S. Public Health Service released a report delineating the mechanisms to optimize the role of pharmacists in the health care team. This report received support from the U.S. Surgeon General and provides evidence that policymakers need to support the utilization of pharmacist as an essential part of the health care team. Spiro noted that the Collaborative hopes that the HITPC and ONC agree that the engagement of pharmacists will improve patient care and help other EPs meet their meaningful use incentives.

Summary of Action Items

Action Item #1: Minutes from the June 6, 2012, HITPC meeting were approved by consensus.